

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61MS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/19/2023
NAME OF PROVIDER OR SUPPLIER METHODIST SPECIALTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 LAYFAIR DRIVE SUITE 500 FLOWOOD, MS 39232		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey along with a Complaint Investigation (CI MS #20011) at the facility from 01/17/23 through 01/19/23. During the survey, the SA determined that the facility was in compliance with the requirements for the Aged and Infirm and cited no deficiencies. The census at the time of the survey was 59 with a bed capacity of 60.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/25/23